Intermediate Care Facilities for Persons with Mental Retardation Questions & Answers

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General

Q1: Can a provider be cited for something that might happen?
A1: Yes. This is especially true in cases of immediate jeopardy. Appendix Q of the State Operations Manual (SOM) issued by The Centers for Medicare and Medicaid Services (CMS) defines an immediate jeopardy as "A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death of a resident." *State Operations Manual, Appendix Q, page 2.*

Q2: Does the state have an appeal process for survey?
A2: A formal appeal process is applicable only when a remedy or adverse action is initiated against a facility. The appeal process related to federal Medicaid certification regulation is found at 42 CFR 431 Subpart D – Appeals Process for NF's and ICF's/MR. The appeal process applicable to adverse action taken against a facility's license is described in IDAPA 16.05.03.308 – Contested Cases.

ADDENDUM: The Idaho Department of Health and Welfare (DHW), Bureau of Facility Standards (Department), and the Idaho Health Care Association (IHCA), representing Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR) established an independent review process for the purpose of resolving disputes with ICFs/MR over federal and state deficiencies cited during a survey. The process was implemented in December 2006.

Q3: What method do you use to select individuals for the sample?
A3: The survey team follows the process described in Appendix J of the Sate Operations Manual (SOM).

Q4: How does the survey team determine scope and severity?
A4: The Compliance Principles found in the Interpretive Guidelines at each Condition of Participation and the Facility Practices included for many regulations, guide the surveyors in determining compliance. However, these were not intended to replace professional surveyor judgment. The State Operations Manual (SOM), on pages J-17 and J-18, states "The threshold at which the frequency of occurrence amounts to a deficiency varies. One occurrence directly related to a life-threatening or fatal outcome can be cited as a deficiency. On the other hand, a few sporadic occurrences may have so slight an impact on delivery of active treatment or quality of life that they do not warrant a deficiency citation."

Q5: Is the record review portion of the survey designed to review only those records that apply to the observations conducted by the surveyors?
A5: The State Operations Manual (SOM) indicates that record review is conducted for:

- Identifying the developmental, behavioral, and health objectives the facility has committed itself to accomplish during the current Individual Program Plan (IPP) period; and

- Identifying what revisions were made to the IPP and determine if the revisions were based on objective measures of the individual's progress, regression, or lack of progress toward his/her objectives; and

- Verifying that needed health and safety supports are in place. This includes reviewing documents to determine if the individual received follow up for health and dental needs identified on the IPP, review of the individual's drug regimen, and if restrictive or intrusive techniques are used, verification that the necessary consents and approvals are in place.

This does not, however, preclude the surveyor from reviewing other portions of the clients' records if necessary to determine compliance. This would be especially true when extended or full surveys are completed.

Q6: Can a facility use cameras to monitor activity in an ICF?
A6: HCFA (CMS) Central Office received an opinion in 1997 to questions they had about security cameras which stated the following:
1. The use of security cameras in the day rooms of ICFs/MR does not violate an individual's privacy;
2. Clients cannot reasonably expect privacy in day rooms;
3. The specially constituted committee must review the facility's use of cameras; and,
4. Whether the cameras are used in place of direct staff supervision must be decided on a case-by-case basis by surveyors.

Q7: Can a facility be reimbursed for respite care?
A7: Facilities cannot receive ICF/MR reimbursement for respite care. However, facilities can admit persons whose care is funded through private sources as long as the presence of private pay persons in the facility does not negatively affect services being provided to the ICF/MR residents, interfere with the delivery of active treatment to ICF/MR clients, or jeopardize the health and safety of either the ICF/MR residents or other people admitted for respite care. A facility can set aside a small number of **non-certified** beds for respite care under the following conditions:

1. The facility would still be engaged primarily in ICF/MR care.
2. Services provided to ICF/MR residents is not hampered.
3. The person is admitted to the ICF/MR if the stay will be over 30 days.
4. The facility must have at least 4 beds for ICF/MR care.

In facilities of 6, no more than 2 beds can be set aside for respite care. In facilities of 7-15, no more than 3 beds may be set aside for respite care. In facilities of over 15, no more than 3 beds or 10 percent of beds may be set aside for respire care, whichever is greater.

Q8: Can photographs be taken during the survey process?
A8: Although the use of photography during the survey process is not required, State Survey Agencies (SAs) may decide to collect photographic evidence to support a finding of non-compliance.

Q9: How long must a facility maintain records?
A9: If the licensure rules and/or Medicare requirements are silent and the provider is a Medicaid provider, IDAPA 16.03.09.330.05 requires Medicaid providers to keep records for at least 5 years.

Q10: Can a family member bring home canned fruits or vegetables to the facility for use?
A10: No, IDAPA 16.03.11.350.09(c)(1) states "All processed or canned foods must be obtained from approved commercial sources or from custom canneries or food processing plants."

Q11: If a hospice patient has a DNR (Do Not Resuscitate) completed when they are of sound mind stating s/he does not want to be resuscitated, can a family member with power of attorney decide to have the patient resuscitated anyway? Which has ultimate authority?
A11: Under the Idaho law, the wishes of the patient are to be followed. So, they should trump the family member's wishes. There is a grey area, however. If the patient, since completing the DNR, has expressed a desire to revoke their original statement and go for resuscitation, then that revocation, even if oral, is to be honored. But, a POA's [Power of Attorney] wishes do not trump the stated wish of the person giving the power. The POA has the obligation to make decisions consistent with the wishes of the patient giving the POA.

Q12: Are there protective equipment guidelines for staff when they bathe individuals? If so, where are they kept?
A12: The facility would need to consult the Code of Federal Regulations (CFR) for OSHA blood-borne standard (1910.1030) and/or the personal protective equipment standards (starting at 1910.132). The CFR for OSHA can be accessed through the U.S. Department of Labor at www.osha.gov.

There will be nothing specific to bathing. The protective equipment needed depends upon the hazards encountered (i.e. blood, chemicals, biting from a client, etc.). Additionally, if the staff is bathing a client and their work shoes get wet, the employer is expected to provide protective foot gear. OSHA does not want workers walking around in wet shoes or clothing for the rest of the day, especially if they are exposed to biological hazards such as blood, fecal material, urine, etc.

Q13: How does a facility apply for special rates?
A13: The facility may contact the Medicaid office at (208) 287-1156 in order to apply for special rates.

Q14: Can an agency request someone from the Bureau attend meetings and trainings provided by the facility, or provide training directly to the facility?
A14: Requests for training or presentations must be sent to the Bureau Chief, either via e-mail through the web-site or in letter form.

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§483.410 Condition of Participation: Governing Body and Management

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§483.420 Condition of Participation: Client Protections

Q1: Does W137 talk about the residents' right to display their possessions, or the right to retain and use them?
A1: One of the Facility Practices statements at W137 states "Individuals have free access to their own possessions and clothing." The Interpretive Guidelines also state "Individuals should not be without personal possessions because of the behavior of others with whom they live." Probes included in the interpretive Guidelines include:

- Are individuals assisted in clothing selection, room decoration and other forms of self expression?
- Are individuals satisfied with the access to and choice of the kinds and numbers of personal possessions they have?
- Are individuals' personal decorative possessions displayed?
- Are individual possessions protected?

We recognize the difficulty in both allowing and encouraging individuals to display personal possessions, and keeping those possessions safe from others. Various issues come into play when assessing compliance at W137.

- A positive living environment which promotes growth and independence is an essential element of the active treatment process. Having to keep one's personal possessions locked up because of the destructive behavior of another brings into question the quality of the living environment.

- Is it appropriate for the person who is destructive to have a roommate? Perhaps the individual's behavior is such that a private room would better serve the needs of all involved.

- What measures has the facility taken which would allow the individual to display personal possessions, yet protect them from destruction (e.g. Plexiglas over posters, firmly secured wall pictures, enclosed cabinets, which would allow possessions to be seen yet protected behind a see through door)?

- Is the individual who engages in the destructive behaviors adequately supervised?

Q2: How many social, religious, and community group activities are required each month to satisfy W136?
Q2: There is not a set number of activities. The type and number of social, religious, and community group activities is based on the assessed needs, interests, and choices of each individual.

Q3: Would it be acceptable for an ICF/MR to use Depo-Provera and/or Lupron in the treatment of sex offenders – providing of course, that the offenders meet ICF/MR level of care requirements and numerous other less restrictive interventions have been tried and found to be unsuccessful?
A3: The use of these drugs would fall under the W128, W261 – W265, and W311 – W317 requirements for drugs used to control inappropriate behaviors. They can be used if approved by the IDT (Interdisciplinary Treatment Team) and specially constituted committee, are used as an integral part of the client's IPP (Individual Program Plan), the behavior outweighs the drugs potential harmful side effects, the client is monitored closely for desired response/adverse reactions, and there is a gradual withdrawal. As for the gradual withdrawal, it may not be appropriate to withdraw the drug. However, the IDT needs to periodically re-evaluate the decision not to attempt a gradual withdrawal based on the individual's progress or other changes in clinical status. It may be that because of the individual's current status or psychiatric illness (if that is what they identify it as) the gradual withdrawal of the drug would be unwise in which case the team must indicate why.

Q4: Must a health facility employee report suspected child abuse, or is the legal obligation restricted to observed acts?
A4: The reporting requirement extends to health care workers "having reason to believe" that a child has been abused, neglected or abandoned, as well as those who observe conditions or circumstances [I.C. 16-1619 (a)]. Even so, there is a fairly extensive gray area surrounding what constitutes "reason to believe."

Q5: Does the Administrator need to be immediately notified of all client to client altercations (including name calling) or only physical contact, and all SIB [Self Injurious Behavior] regardless of severity (i.e., hand sucking vs. notable injury)?
A5: The following clarification was received from CMS:

W153 – The facility must ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, are reported immediately to the administrator…

The term "immediate" in the above regulation truly means immediate. Policies and practices which allow time intervals for reporting to the administrator (e.g., within 2 hours, etc.) are not allowed. This requirement for immediate reporting includes ALL allegations, regardless of severity or frequency. For example, client to client aggression and self-injurious behaviors must be reported immediately to the administrator, even in situation where there is no observable injury.

The administrator (not a designee) is notified of the incidents during his/her routine hours of work (e.g., 8:00 a.m. – 5:00 p.m.) Monday – Friday when he/she is on duty. A rotating on-call schedule is acceptable for other hours of the day/week, however, the staff designated to be on-call must have the authority to take whatever actions necessary to ensure clients are protected. None of the above precludes the administrator from going on vacation, etc. and appointment a qualified staff person to act on the administrator's behalf when he/she is absent.

Q6: Are minor injuries of unknown origin (i.e. a small scratch) required to be reported immediately to the Administrator?
A6: Yes. All injuries, regardless of size and/or severity, need to be reported immediately to the Administrator or AOD (Administrator On Duty).

Q7: Does the reporting of incidents to the AOD meet the requirements of reporting to the Administrator?
A7: Yes.

Q8: Who can serve as the Administrator Designee, and what authority are they required to have?
A8: Anyone can be appointed Administrator Designee per the Administrators choosing (i.e. QMRP). The AOD would be expected to have the same authority as the Administrator as it relates to ensuring the protection of individuals (i.e. the ability to suspend staff pending an investigation due to allegations/suspicion of abuse, neglect, and mistreatment, to implement policy to begin an investigation of abuse, neglect, mistreatment, etc.). The AOD does not necessarily need to have the ability to hire and fire staff. The authority and qualification requirements of the AOD would need to be defined within the facility's policy.

Q9: Is the facility required to obtain consent when an individual receives anesthesia?
A9: **W124** – The facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.

The Facility Practices section states "Individuals and their representative, if applicable, are aware of the individual's medical condition and treatment, therapies, services and other treatment or prescribed approaches being received, the reason for their use, as well as any risks involved in those treatments or approaches.

The guidelines state "The term 'attendant risks of treatment' refers to all treatment, including medical treatment."

Q10: Is the use (by the client) of a company computer, network and internet access a right or a privilege?
A10: Use of a company computer for entertainment vs. work is governed by the company. The company should have "rules" for its use.

However, if an individual in the ICF wants to learn to use a computer (either for fun or for work purposes), then the team would need to determine if the use is appropriate. If so, the team would then need to figure out how to provide computer access, as well as and assistance for its use, to the individual. If the reason for the computer is over and above that of fun or hobby, such as communication, work and perhaps socialization, then the computer is no different than any other type of assistive technical device an individual would need and the ICF should provide it. The ICF can obtain a donated one, talk to the State Tech Group about acquiring one, lease one, or buy one. Having their needs met is the right of the individual.

The company should use caution as access to a company computer may provide an excuse for some staff that may chose to use the computer inappropriately. For example,

the individual may then be blamed if pornography is found on the computer, the computer breaks, etc. Additionally, the company's information may be at risk for being lost or accessed inappropriately if the computer has multiple users (i.e. individuals and staff).

Q11: If a computer is made available to one client should all clients be encouraged to utilize this as a training resource?
A11: If the company has made a computer available to one individual for a specific use, it does not mean the company has approved all individuals use of the computer. Additionally, each individual should be assessed to see if current technology has a role in their lives. This should include, but not be limited to, cell phones, e-mail, answering machines, computers, etc.

Q12: Can the computer be used as a reinforcer if it is a privilege?
A12: If a computer is available for general use by clients, then use may be based on the clients meeting the "rules" of its use. If the "rules" (e.g., no food or beverages over the keyboard, no use unless cleared to use independently, or other community rules similar to what the library may impose on their computer use) are followed, then its use would be neutral, not necessarily a reinforcer or a privilege.

If the company assesses and chooses to use the computer as reinforcement for an individual, it would need to be part of a written behavior plan. Additionally, if the computer were used as a communication device for an individual, its use could not be as reinforcement.

Q13: Regulations: §483.420(a)(9) Tag W133 - "Ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice." and §483.420(a)(9) Tag 134 - "and to send and receive unopened mail." – Does this pertain to electronic mail and chat room contact?
A13: Yes, electronic mail and chat room contact would be included, unless it is part of a training program with plans to teach use and appropriateness, and then fade the restrictiveness. Additionally, HRC approval and guardian consent would need to be obtained for any restrictive components of the program.

Q14: If internet access is utilized as a recreational resource, communication tool, and is identified in the client's IPP, does the facility have to furnish this resource?
A14: As stated previously, if the computer is used as a communication tool the facility is obligated to provide the device.

Q15: If a client wants to post pictures of himself and pictures of another client is this restricted? If so, how?

A15: If the client is their own guardian and wants to post pictures of him/herself, then they have a right to do so. If the client has a guardian, then the guardian would have to make the decision to allow the individual to post pictures or not. Posting pictures of another client (peer, friend, etc.) would require the same questions to be asked regarding the other individual.

Additionally, as with dating, the facility must ensure that no individual residing at the facility is taken advantage of, that each individual understands their right to say "no," and that each individual understands the possible consequences of saying "yes."

Q16: Can an individual residing in an ICF/MR request a lock be installed on his bedroom door to keep other individuals out?
A16: It is acceptable for an individual to have a lock on their bedroom door as long as the individual is able to independently operate the lock and would be free to enter and exit at will. Staff should have access to a key as well in case of emergency situations. The lock can be a standard bedroom door knob lock with a thumb-switch on the inside or a deadbolt that has a thumb-switch on the inside. Padlocks would not be acceptable.

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§483.430 Condition of Participation: Facility Staffing

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§483.440 Condition of Participation: Active Treatment Services

Q1: Can an objective be clear enough that it serves as both the objective and the specific methods to be used?
A1: Objectives and methods are clearly identified as separate requirements in the regulations.

The federal regulations at 483.440(c)(4)(i-v) state that training objectives must:
W229 – Be stated separately, in terms of a single behavioral outcome;
W230 – Be assigned projected completion dates;
W231 – Be expressed in behavioral terms that provide measurable indices of performance;
W232 – Be organized to reflect a developmental progression appropriate to the individual; and
W233 – Be assigned priorities.

The regulations go on to state at 483.440(c)(5)(i-vi) that each written training program designed to implement the objectives in the individual program plan must specify:
W234 – The methods to be used;
W235 – The schedule for the use of the method;
W236 – The person responsible for the program;
W237 – The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives;
W238 – The inappropriate client behavior(s), if applicable; and
W239 – Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

The Facility Practices statement at W234 states the methods are to provide clear directions to any staff person working with the individual on how to implement the teaching strategies. The objective, on the other hand, states the desired behavioral outcome. Objectives do not include all information necessary for ensuring consistent implementation by providing clear instructions to staff, such as the type and frequency of reinforcement, what to do if the individual does not correctly achieve each step or task, etc. The degree to which a task must be broken down, and the resulting number of steps in a program, is based on the individual's abilities as identified in the comprehensive functional assessment.

Q2: The interpretation at W262 read: "For example, if the physician changes the dosage of a medication in accordance with the drug treatment component of the active treatment plan to which the legally authorized person has given consent and which has already been approved by the committee, then there is no need for the committee or the legally authorized person to re-approve the plan. Generally, this would also apply if the medication was changed to another within the same therapeutic class or family." It is this last sentence that is causing confusion. Then literally, this seems to mean that the committee can approve a "class" of medications. Is this correct?
A2: W262 is about the Committee and how it provides a "conscience" for facility practices which are intrusive or restrictive; W262 is really not about the use of drugs per-se, but assuring that facility practices assure protections and rights – including informed consent and assuring that approved plans which are restrictive stay within the bounds of what has been approved and the committee monitors for effectiveness.

Informed consent does not begin with a "class" of drugs, it begins with the drug which is being prescribed for a specific condition – along with the advantages, disadvantages, risks/benefits, possible adverse effects of that drug, etc. It is this information which is provided so that consent can in fact be "informed."

Once informed consent is obtained and a plan is approved, the interpretive guidelines allow for some flexibility on the part of the Committee as long as the context of treatment or plans remains the same.

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§Condition of Participation: Client Behavior and Facility Practices

Q1: What is the definition of restrictive? Who defines restrictive?
A1:A program to manage inappropriate behavior would be considered restrictive if it infringes on the rights of, or presents a risk to, the individual. Examples of restrictive procedures include, but are not limited to, the following:

- The use of drugs to modify or control behavior.
- Restitution.
- The use of items, procedures, or systems which are potentially stigmatizing to the individual or otherwise would represent a substantial departure from the behavior of comparable peers without disabilities, such as a locked residence without being given a key or ability to use the key, use of a high crib with bedrails for an adult who gets out of bed at night and wanders or upsets others, wearing a jumpsuit backwards to prevent an individual from stripping clothes off, and wearing gloves to prevent an individual from picking at his/her skin.
- Positive Practice and Overcorrection training of extensive duration.
- Satiation.
- Physical Restraint, defined as any manual method or physical or mechanical device that the individual cannot remove easily, and which restricts the free movement of, normal function of, or normal access to a portion or portions of an individual's body (e.g. prone or supine restraint, basket holds, arm splints, posey mittens, helmets, straight jackets).
- Application of painful or noxious stimuli.
- Use of time-out rooms.
- Contingent denial of any right or earning of a right as part of a behavior shaping strategy.
- Behavioral consequences involving issues of client dignity.
- Restrictions on community access.
- Restring free access to personal belongings.
- Time-out procedures.
- Forced compliance.

Keep in mind that this list is not all inclusive.

Q2: Can a facility choose to ignore SIB such as repeatedly slapping one's self on the face/head hard enough to cause pain and redness or bumping head on a wall (but no obvious external injury) if they feel the behavior is attention seeking and attending to the behavior will only increase it's frequency?

A2: If these types of behaviors occur, they cannot be simply ignored due to the potential for internal damage to eyes, ears, brain, etc. If the facility ignores a behavior in an attempt to extinguish the behavior, and that approach results in tissue damage, or could lead to injury for the individual, the failure of the facility to protect the individual can result in deficient practice. The facility must identify when staff should intervene short of tissue damage, and develop and implement behavioral interventions to address the attention seeking behavior.

Q3: If a facility has programs in place that call for an individual (child or adult) to stand in the corner or sit on the floor for anywhere from 1 – 10 minutes (whatever is specified in the program) as a consequence for a specific behavior, does this procedure constitute a restrictive intervention and, therefore, require an informed consent from the parent/guardian?
A3: Since the use of this technique will work only if the individual does not like to be removed from an activity or from people, this would be considered a restrictive program. Since this is a restrictive program, it needs to go through the usual review and approval processes. In addition, the plan needs to identify how it will move to lesser restrictive measures.

Q4: Regulation: §483.450(b)(1) Tag W274 – "The facility will develop written policies and procedures that govern the management of inappropriate client behavior" – Will this policy need revision to take into account what is to be acceptable conduct using facility computers, network, and internet access, etc?
A4: Yes. See questions related to computer use by individuals residing in ICFs/MR under the Condition of Participation for Client Protections.

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§483.460 Condition of Participation: Health Care Services

Q1: Are Physician's Re-Cap orders required to be revised every 60 days? If not, should the nurse complete Re-Cap orders but not have them signed by the physician?
A1: Neither ICF/MR Federal Regulations or State Rules include language that requires Physician's Re-Cap orders to be revised every 60 days.

If the nurse is completing Re-Cap orders but not having them signed by the physician, it may be beneficial to keep this documentation in a location other than on physician's order sheets as it may appear there are orders that have not been signed.

Q2: If a physician order is received via fax, is the facility required to ensure the physician signs and dates the order again when seen in person?
A2: Faxed orders do not need to be signed and dated again by the physician as long as the facility maintains on file an original signature of the physician writing the order which would allow authentication of the signature through comparison.

Q3: Can the facility purchase over-the-counter [OTC] items ordered by the physician (e.g., Desitin, vitamins, aspirin, fiber tablets, milk of magnesia, etc.), copy the physician's order, and attach the copied order to the OTC drug?
A3: The facility cannot label OTC medications pursuant to a physician's order; that may only be done by the pharmacy. Although the cost involved is understood, however, a facility labeling medication is a violation of federal law as well as stated law, specifically IDAPA 27.01.01.0159.02 and IDAPA 27.01.01.0257.01.f.

All drugs supplied shall be labeled so as to insure that recalls can be effected and that proper control and supervision of such drugs may be exercised. Federal law would consider any labeling of an OTC item, outside what a pharmacy is allowed to do pursuant to a physician's order, to be misbranding.

Q4: Must controlled drugs be maintained under a double lock system?
A4: The purpose for the double locking is to limit access to scheduled drugs. If the individual self-administers medications there is no need for a double lock in the individual's room if the controlled medication is secured, the storage area is appropriate for the medications, and it is properly serviced.

However, if the controlled drugs are kept in a central location (i.e. locked in a cabinet in the bathroom or laundry room) and the individual can not yet self administer, the double lock requirement would apply.

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§483.470 Condition of Participation: Physical Environment

Q1: Does W427 require a window to the outside or a window that opens to the outside?

A1: 483.470(e) is the Standard of Heating and Ventilation. 483.470(e)(1)(i), or W427, falls under this standard and is, therefore, directly related to heating and ventilation. The interpretive Guidelines provide further information regarding the intent of the regulation,

and state that "Since a door serves primarily to provide egress rather than to perform the ventilation and aesthetic functions of an outside window, it may not be used for room ventilation in place of a window."

Additionally, the Sate Life Safety Code requires operable windows and IDAPA 16.03.11.120.04.c referencing client bedrooms, states that "…one-half (1/2) of the window area must be openable."

ADDENDUM: The Fire Safety Code Chapter 33 states the following regarding bedroom windows that are a secondary means of escape from sleeping rooms (K120):

33.2.2.3(c) * It shall be an outside window or door operable from the inside without the use of tools, keys, or special effort that provides a clear opening of not less than 5.7 ft2 (0.53 m2). The width shall be not less than 20 in. (51 cm), and the height shall be not less than 24 in. (61 cm). The bottom of the opening shall be not more than 44 in. (112 cm) above the floor.

Q2: Can an individual residing in an ICF/MR request a lock be installed on his bedroom door to keep other individuals out?

A2: It is acceptable for an individual to have a lock on their bedroom door as long as the individual is able to independently operate the lock and would be free to enter and exit at will. Staff should have access to a key as well in case of emergency situations. The lock can be a standard bedroom door knob lock with a thumb-switch on the inside or a deadbolt that has a thumb-switch on the inside. Padlocks would not be acceptable.

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§483.480 Condition of Participation: Dietetic Services

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